SIENA HILLS PRIMARY CARE

Demographics

PATIENT INFORMATION		
PATIENT NAME:		GENDER: MALE / FEMALE
ADDRESS (CITY, STATE, ZIP CODE):		
DATE OF BIRTH: / /	AGE:	SOCIAL SECURITY #:
PRIMARY PHONE #:	SECONDARY PHONE#:	
Permission given to leave results and advice on my **voicemail**. PLEASE CIRCLE: **YES / NO**		
Permission given to send **text message** reminders. PLEASE CIRCLE: **YES / NO**		
EMAIL ADDRESS:		
WOULD YOU LIKE TO ENROLL IN OUR PATIENT PORTAL TO VIEW RESULTS AND SEND US MESSAGES? PLEASE CIRCLE: **YES / NO**		

ADDITIONAL INFORMATION		
RACE (CIRCLE): CAUCASIAN / HISPANIC / AFRICAN – AMERICAN / ASIAN / PACIFIC ISLANDER / NATIVE AMERICAN / OTHER:		
ETHNICITY (CIRCLE): NOT HISPANIC OR LATINO / HISPANIC OR LATINO / OTHER:		
PREFERRED LANGUAGE (CIRCLE): ENGLISH / SPANISH / MANDARIN / OTHER:		
CIRCLE ONE: SINGLE / MARRIED / SEPARATED / DIVORCED / WIDOW / DOMESTIC PARTNER		
SPOUSE NAME:		PHONE #:
PATIENT EMPLOYER:	JOB TITLE:	WORK PHONE #:
EMPLOYER ADDRESS (CITY, STATE, ZIP CODE):		

PHARMACY INFORMATION	
PHARMACY NAME:	
PHARMACY CROSS STREETS:	
MAIL ORDER PHARMACY (CIRCLE): EXPRESS SCRIPTS / OPTUMRX / CVS CARE MARK / OTHER (LIST):	

EMERGENCY CONTACT / AUTHORIZED CONTACT	
EMERGENCY CONTACT NAME & RELATIONSHIP:	
EMERGENCY CONTACT PHONE#:	CELL#:
*I authorize the doctors and staff of the Clinic to discuss health information with my Emergency Contact, PLEASE CIRCLE: **YES / NO**	
AUTHORIZED CONTACT NAME & RELATIONSHIP: SAME AS EMERGENCY CONTACT? PLEASE CIRCLE: **YES / NO**	
OTHER AUTHORIZED CONTACT NAME & RELATIONSHIP:	
OTYHER CONTACT PHONE #:	CELL#:
POWER OF ATTORNEY FOR HEALTHCARE: YES / NO *IF YES, PLEASE PROVIDE COPY OF POA	

PRIMARY HEALTH INSURANCE INFORMATION PLEASE BRING YOUR ID AND INSURANCE CARD TO THE FRONT DESK WITH THE COMPLETED FORMS	
PRIMARY INSURANCE:	ID#:
	GROUP#:
INSURANCE MAILING ADDRESS:	
INSURANCE PHONE#:	
POLICY HOLDER NAME:	POLICY HOLDER DOB: / /
RELATIONSHIP TO PATIENT:	POLICY HOLDER SOCIAL SECURITY#:

SECONDARY HEALTH INSURANCE INFORMATION	
SECONDARY INSURANCE:	ID#:
	GROUP#:
INSURANCE MAILING ADDRESS:	
INSURANCE PHONE#:	
POLICY HOLDER NAME:	POLICY HOLDER DOB: / /
RELATIONSHIP TO PATIENT:	POLICY HOLDER SOCIAL SECURITY#:

By signing below as the patient/parent/guardian, I acknowledge AND certify that all information provided to *Siena Hills Primary Care is complete and accurate.*

Patient/Parent/Guardian Signature:

Date:

SIENA HILLS PRIMARY CARE

Office Policy

Thank you for allowing Siena Hills Primary Care (SHPC) to be your health care provider. We are committed to providing each patient with quality health care. All patients are required to review and sign our Office Policy prior to seeing the physician. We will be happy to answer any questions and to provide a copy upon request.

Appointments: If you are unable to keep your appointment, please call 24 hours in advance to reschedule or cancel your appointment.

Receipt of Notice of Privacy Practices:

SHPC has posted the Notice of Privacy Practices on its website www.sienahillsprimarycare.com. This document is required by law and explains our duties and obligations with respect to protecting your health information. A printed copy is available for review in the waiting room and also upon request. Your signing below acknowledges receipt this Policy.

Medical and Insurance information:

By signing below, you certify that all information that you have provided to SHPC is complete and accurate. It is the patient's responsibility to inform the office staff of any changes such as address, telephone, insurance coverage, and medications. You authorize sharing of medical records with other physicians on your care team, fax transmission of medical records, and electronic verification of your previous prescriptions.

Financial Responsibility:

Payment for copays, coinsurance, and deductible charges are due at the time services are rendered. Insurance coverage is a contract between you (the patient) and your insurance company. It is your responsibility to understand your specific insurance benefits, your financial responsibility, and which doctors are in your insurance network. Please contact your insurance company with questions and/or concerns. Please provide our office staff with a copy of your insurance card. As a courtesy to our patients, we will process claims to your insurance and assist in getting your claims processed. Since it is the patient's responsibility to update our staff of any insurance changes, failure to do so could result in the delay or denial of insurance payment. If this happens, then you will be responsible for the payment. If your insurance company denies a claim or does not pay a claim within 90 days from the date of billing, you will be financially responsible for those charges. Labs and Imaging tests that are ordered by a SHPC doctor are separate from our services and will be billed by another health care provider.

Payment and Collections:
We understand that financial circumstances may vary. If you have any questions about your statement or are unable to pay your balance in full, please call our billing department at (702) 242-6911. Payments that are denied by the Credit Card Company or the bank will be your responsibility, including all fees incurred from denied payments. In the event you (the patient) receive a payment check from your insurance company for services which we provided, please endorse the check, make it payable to "Siena Hills Primary Care", and mail the check to our office, along with a copy of the paperwork so that we can apply the payment to your account.

Failure to pay or to set up a payment plan within 90 days of the balance due date will result in your account status to be delinquent and will be transferred to a Collection Agency. It is patient's responsibility for additional fees to the collection agency (typically 35%), interest rates, attorney fees, court costs, and filing fees related to this matter. If you have any questions regarding the status of your account, please contact our billing department at (702) 242-6911.

Assignment of Benefits: By signing below, you hereby guarantee payment of all charges incurred with SHCP and hereby assign and direct any payments for all medical services under this claim to be payable to "Siena Hills Primary Care." You authorize the release of any medical information requested by your insurance company regarding the assignment.

****

By signing below as the patient/parent/guardian, I acknowledge that I have read, understand, and will comply with the Siena Hills Primary Care Office Policy as stated above.

DATE:
Patient/Guardian Printed Name:
Patient/Guardian Signature:

SIENA HILLS PRIMARY CARE

Patient Medical History

Reasons for visit today: _____

Check here if auto accident ___ Check here if injury or illness is work related _____

Please list previous surgeries and dates performed: _____

_____

Please list all previous and current medical conditions: _____

_____

_____

Occupation: _____ Single/ Married/ Divorced/ Widow/ Other

Allergies: _____

Tobacco use: Never | Former - date quit _____ | Current ___ packs a day for ____ years / Chew / Cigars / Pipe

Alcohol use: Y / N Typical number of drinks_____ per day / week

Please list all current medications, doses, and number of times a day taken. Also include over the counter medications:
_____

_____

_____

Please list recent physicians seen: _____

_____

Family history:

Mother – living/deceased; medical conditions: _____

Father – living/deceased; medical conditions: _____

Other relatives: _____

Please note dates and results of any recent test or treatments within the last 5 years:

Pap test_____ Mammogram_____

Colonoscopy_____ Bone Density _____Cardiac testing_____

Vaccines: Prevnar-13 _____ Pneumococcal -23 _____ Shingles _____

SIENA HILLS PRIMARY CARE

SYSTEM REVIEW

Please circle if you have recently had the following: NAME_____

GENERAL

fatigue overall weakness obesity weight gain / loss loss of appetite fever chills sweats insomnia headache loud snoring anemia cancer

EYES, EARS, NOSE, THROAT

vision problems eye problems hearing loss ringing in ears nose congestion runny nose allergies postnasal drip bloody nose sinus pain mouth / tongue sore tooth decay
sore throat hoarseness neck lump

HEART / VASCULAR

chest pain high blood pressure short of breath on exertion or lying down swollen ankles palpitations dizziness lightheadedness loss of consciousness heart murmur

LUNGS

pneumonia asthma chronic bronchitis shortness of breath cough phlegm/sputum wheezing coughing up blood abnormal chest X-ray previous smoker tuberculosis

DIGESTIVE

heartburn burping trouble swallowing abdominal pain ulcers nausea vomiting jaundice hepatitis gall bladder disease diarrhea constipation excess gas vomiting blood
black or tarry stools rectal bleeding hemorrhoids hernia

GENITO-URINARY

trouble passing urine stones blood in urine loss of urine control urgency frequency decreased sex drive sexually transmitted disease (what kind?_____)
Male: decrease in urine flow erection difficulty penile discharge or lesion
Female: heavy or abnormal menstrual period vaginal discharge dryness breast lump hot flashes last period_____ # of pregnancies_____ live births_____ miscarriages

MUSCULO-SKELETAL

arthritis joint pain stiffness swelling muscle ache gout osteoporosis
Where: shoulder arm elbow wrist left / right hand Hip thigh
knee leg ankle left / right foot neck mid-back lower back

NEUROLOGICAL

stroke weakness of one extremity tingling or burning sensation numbness imbalance walking tremor memory loss seizures vertigo altered speech

PSYCHIATRIC

Depression moodiness poor motivation loss of enjoyment anxiety panic stress

ENDOCRINE

Diabetes diabetic complications frequent thirst and urination hot or cold intolerance thyroid problem excess hair growth abnormal hair loss

SKIN

Rash lesion mole dryness itching psoriasis discoloration nail abnormality